☐ Two-Step TST

Hawaii Department of Health - Tuberculosis Control Branch

Today's Date _____

1. Name: _____
Last First Middle Initial Maiden Name

Home Address: _____
Street Number and Name Apartment Number / Subdivision

_____
City State Zip Code

Mailing Address: _____
Street Number and Name Apartment Number / Subdivision

_____
City State Zip Code

Month Day Year
2. Date of Birth: _____ /_____ /_____
3. Age: _____
4. Sex: ☐ Male ☐ Female
5. Occupation: _____
Employer: _____
School: _____
6. Telephone Numbers:
Home: ( ) _____
Work: ( ) _____
Cell: ( ) _____
7. Physician: _____
8. Medical Insurance: _____

9. Marital Status:
☐ Married ☐ Widowed
☐ Divorced ☐ Separated
☐ Never Married

10. Country of Birth: _____
11. ☐ US Citizen ☐ Refugee
☐ Immigrant ☐ Other: _____

12. If Foreign Born: Month Day Year
Date arrived in US: _____ /_____ /_____
Date arrived in HI: _____ /_____ /_____
13. Primary language: _____

14. Race / Ethnicity (check all that apply):
☐ White / Caucasian ☐ Hawaiian ☐ Chinese ☐ Micronesian ☐ Samoan ☐ Hispanic
☐ Black / African American ☐ Filipino ☐ Korean ☐ Marshallese ☐ Guamanian or Chamorro
☐ American Indian or Alaskan Native ☐ Japanese ☐ Vietnamese ☐ Palauan ☐ Other: _____
Specify

15. **REASON FOR EXAMINATION** (check one only):
☐ A. Foodhandler ☐ C. Care / Foster Home Operator ☐ E. Health Care Worker ☐ G. Contact/Source (PHN:_____)
☐ B. Student ☐ D. Care / Foster Home Resident ☐ F. School Employee ☐ H. Immigration ☐ O. Other:_____

16. Were you sent by a Doctor? – If yes, Doctor's name: _____ ☐ Yes ☐ No
17. Have you had a previous positive skin test (swollen)?..... ☐ Yes ☐ No
18. Have you taken medicine for Tuberculosis?..... ☐ Yes ☐ No
19. Have you received any immunizations within the past 4 weeks?..... ☐ Yes ☐ No
20. **FEMALES - ARE YOU PREGNANT?**..... ☐ Yes ☐ No
21. **FEMALES - ARE YOU BREASTFEEDING?**..... ☐ Yes ☐ No

Notes (official use only):

TB ID#: _____

22. Authorization for testing, release of medical information, and acknowledgement of understanding:

a) I hereby authorize the Department of Health to perform a tuberculin skin test and chest x-ray, if necessary, to the child (<18 years old), whose name appears on this form.
b) I hereby authorize the Department of Health to release any results and Chest Clinic Physician's recommendations to the doctor named above.
c) I understand that I must return in 48-72 hours for reading of the tuberculin skin test and I agree to return for any test results as instructed by Department of Health staff.
d) I understand that chest x-rays taken at the Tuberculosis Control Branch are to be used ONLY for Tuberculosis Control purposes.

Print Name: _____ Signature: _____ Date: _____/_____/_____
Patient, Parent, Guardian, or Caregiver Patient, Parent, Guardian, or Caregiver

---------- **** Please do not write below this line **** **----------**

TST 1: Given: _____ Site: LFA / RFA Initials or Signature: _____
Read: _____ Result: _____mm Initials or Signature: _____

TST 2: Given: _____ Site: LFA / RFA Initials or Signature: _____
Read: _____ Result: _____mm Initials or Signature: _____

IGRA 1: Affix IGRA Label# Here Collected:_____ Initials: _____ Result: N / P / I

IGRA 2: Affix IGRA Label# Here Collected:_____ Initials: _____ Result: N / P / I

Reason for Clinic Registration
☐ Verified TB ☐ Contact
☐ Suspected TB ☐ Reactor
☐ Previous TB ☐ Converter

Census Tract: _____

SSN (last 4 digits): ☐☐☐☐

CC#: _____

Admit Date: _____

Discharge Date: _____

INITIAL X-RAY	PHYSICIAN NOTES	RETAKE X-RAY	PHYSICIAN NOTES	FOLLOW-UP
☐ Negative for TB	_____	☐ Negative for TB	_____	☐ None ☐ FHC Given
☐ Suspicious	_____	☐ No change	_____	☐ LTBI Rx ☐ FHC Mailed
→ ☐ *Cavitary*	_____	☐ Suspicious	_____	☐ Admit ☐ LTBI Rx Letter
☐ Other	_____	☐ Other	_____	☐ Other
Date: _____	_____	Date: _____	_____	☐ Pt Other Letter
Initials: _____	_____	Initials: _____	_____	☐ PMD Letter: _____